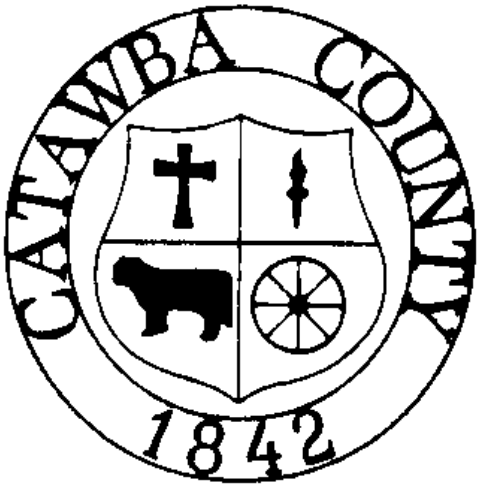

Mental Health Services Of Catawba County

Draft Local Business Plan

April 1, 2003

Section V. Access to Care

Contact Person:
John M. Hardy, Area Director
3050 11th Ave. Dr. SE
Hickory, NC 28602
Phone – 828- 695-5900

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
Contact	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	04/01/03

Item: V. Access To Care 1a

Goal: The local business plan describes the operation of a local access system in compliance with the uniform portal of entry and exit in the State Plan
-There is a clear description of how people can access the mh/dd/sa system through multiple points of entry throughout the service area.

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
We currently have a centralized Access system in place with multiple points of direct referral including: Early Childhood Intervention Services (ECIS), judicial system, Exodus House (A&D TX Center), NA/AA, physician offices, school systems, Salvation Army, Western Carolina Center Outreach, DSS, Public Health, etc. If services are indicated, independent entry points into the MH/DD/SA system currently consist of DSS Work First, local hospitals, 56 local child care centers, local jails, and the Criminal Justice Partnership Program (CJPP)	Determine # of increased portal sites/access locations needed for 30 minute/mile requirements based on review of active client mailing addresses (looking at concentrations) and additional community demographic data Combine Access/ES staff in multiple locations across the catchment area within the 30 minute /mile radius, making provisions for 24/7 face to face or phone requests followed by referral to appropriate providers. Recruit bilingual staff for Access.	Capacity of qualified staff Funding for additional staff 24/7 Recruitment of bilingual staff Transportation, particularly after regular business hours Hospitals have different operating procedures from 8:00am to 5:00 pm then they do during after hours

With a phone call or face-to-face, information is gathered to make necessary assessment referral based on clinical priority of the presenting problem (emergent, urgent, routine) During regular business hours, Access staff see emergent cases on-site or at the client's location if indicated, and/or facilitate arrangements for that face-to-face assessment contact. 24/7 Emergency Services are available after business hours, centralized through the local 911 system. Phone contact is employed most often in assessing the client needs, but face-to-face assessments are done at local hospital ERs for more urgent demands. Laptops, and electronic medical records are available for use in referencing any crisis plans for clients already active in the system. Additionally, if a client is entering the system for the first time, this capacity allows information to be entered into the medical records system immediately (preventing duplication or delay) Access staff are available to do on-site visits with DSS, Public Health, etc. clinicians to assess varying situations for the appropriateness of MH services, and facilitate that entry into the system Access staff assess the need for any specialized services such as interpreters, transportation, resources for mobility impairments, etc. and the process for arranging those supports is immediately put in place	Work with local hospital management to increase staff privileging so that they are able to provide access services (e.g., nursing staff complete all access requirements for MH/DD/SA system entry) Identify other community workers on-call 24/7 who could be enlisted to perform MH screenings/ assessments for needed services (e.g., DSS social workers, ALFA- Aids Leadership Foothills Association, Rape Crisis Center, Family Care Services) Coordinate services with the centralized NC 1-800 number as it is established and functional Explore the need for hiring additional staff to be stationed in the community at access portals Train specific staff of community agencies in completing access materials Explore the development of a County web-page self-referral form. Have screening/inventory form on depression, anxiety, SA, etc. Consider who would monitor, confidentiality, HIPPA, etc. Look at utilizing volunteers and consumers as the Access system is refined and continually expanded	

Several bilingual staff of the Area program are available to assist the Access unit if initial interpreter services are needed (Spanish, Hmong)		

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
Contact	John M. Hardy, Area Director, (828)695-5900, fax (828) 695-5949, johnh@catawbacountync.gov
Submission Date	04/01/03

Item: V. Access To Care 1b

Goal: The local business plan describes the operation of a local access system in compliance with the uniform portal of entry and exit in the State Plan.
-The document attached describes the development and distribution of information to guide and assist community members in accessing services.

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Mental Health Services of Catawba County (MHSCC) video has run on cable TV for three years, describing an overview of services and providing access information	Update the Mental health video to prioritize accessing services Research the possibility of an Access web–site.	Funding availability Obtaining IT infrastructure and financial support for consumer friendly Access process without multiple layers
Information on accessing MHSCC is distributed in the following formats: MHSCC Annual Report Agency web-site On-going ads running on the government channel Staff participation on various organizational boards in the community	Develop a brochure outlining how to access MH/DD/SA services; distribute brochure in multiple places such as mall, grocery stores, etc.; have translated versions of brochures in languages representative of the community, also in Braille. Work in conjunction with Latino and Hmong associations to maximize distribution of information about service access (verbal, written, etc.)	Lack of consistent messages to LMEs vs. Provider Network to support a consumer friendly system as reported by private providers

Listing in the Catawba County United Way Resource Directory Presentations to various agencies/groups Participation in Health Fairs as requested Presentations through EAP program Latino community has translated varying information regarding Mental Health, Public Health and DSS Lenoir-Rhyne College has a "building community through diversity" grant to provide a series of community forums in which we participate about how we use diversity to develop infrastructure and growth in areas of education. Diversity training is provided to our staff as we collaborate with them in understanding basic diversity, and its application to providing accessible services State 800 # available 24/7 Advertise under multiple headings in the phone book Advertise service accessibility on local radio station	Explore possibility of web-site in Spanish Explore other ways of communication with regard to literacy and varying levels of understanding Explore involvement in United Way local 211# proposed as an information clearinghouse, currently in developmental stages within the county Partner with church groups to reach diverse population Look into the possibility of local 800# for consumers to have access to LME information Explore the development of an Access portal that allows a variation of response, i.e. info requests only vs.crisis call Conduct assessment and data collection to see time needs/hours of day of customers to determine if changes need to be implemented to improve customer service Phase in more full-service operation for 24/7 Access/referral Conduct a time-limited pilot experiment of extending hours of Access to 7:00 pm to document # of calls and needs, to be used in further planning and development Per CFAC recommendation, explore the possibility of a consumer-run phone line to help with appointment reminders, to supply information and support for consumers	

	In addition will explore a consumer-run drop-in center to assist consumers in accessing services	

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

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Contact	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	04//01/03

Item: V. Access To Care 1c

Goal: The local business plan describes the operation of a local access system in compliance with the uniform portal of entry and exit in the State Plan.
-A policy is attached that governs formal procedures to assure that individuals are not inappropriately denied access during the screening, initial assessment or referral process

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Policy was generated in COA accreditation process to assure appropriate access and has been in place and practiced since then. (Attachment A)		

Reviewers Comments:

Attachment A-Intake/Access Policy

Attachment A – Intake/Access Policy – Access to Care

Mental Health Services of Catawba County

POLICIES AND PROCEDURES

ACTIVITY: CLINICAL SERVICES	Number:	3.003b
	Effective Date:	03/05/82
SUBJECT: INTAKE/ACCESS PLAN	Amended Effective:	11/10/00
	Board Approved:	01/12/95
	QMT Approved:	02/14/03

POLICY:

It is the policy of Mental Health Services of Catawba County (MHSCC) to assume primary responsibility for the citizens of Catawba County within all areas of mandated purview. All requests made to MHSCC by the community will be handled at the level of clinical responsibility indicated by the request. The area authority shall determine the overall capabilities of the clinic by assignment of resources, and by appropriate policy directing services to be provided. MHSCC will adhere, in as far as is possible, to the principles of "single-portal-of-entry'" to the mental health system and deinstitutionalization/least restrictive mode of care.

All residents of Catawba County who have a mental or emotional disorder, a substance abuse problem or a developmental disability are potentially eligible for services from this agency and are not inappropriately denied access during any screening, initial assessment, or referral process. Intake/Access is defined as the evaluation of need and the placement of consumers into the appropriate services.

PROCEDURE:

1. Centralized Intake/Access services are offered on a 24-hour-a-day, seven-day-a-week basis. During business hours designated professional staff of the Intake/Access Unit provides this service. Emergency services are provided by assigned staff to assure Intake/Access other than during clinic hours.
2. Professional staff are assigned to Intake/Access service by job description, assuring continuous coverage as well as backup coverage for services of an emergency nature.
3. Intake/Access technically commences at the time of request for mental health services. If the request is by phone, appropriate calls are forwarded to Intake/Access. During the intake call every effort is made to manage requests for services with a scheduled appointment. These basic procedures also apply to persons who walk into the Mental Health Clinic requesting assistance.
4. The Intake/Access worker's initial interview with a client is the first clinical triage and most important link in the Intake/Access process. The Intake/Access staff determines if the caller is in need of immediate attention, can best be served by coming to the clinic for scheduled screening, or requires information/referral only. These determinations are also made by face-to-face interview with all walk-in requests.
5. Most requests for services by phone are subsequently scheduled with the appropriate clinician or program. Determination is made by the Intake/Access worker as to the best program staff to fit the client's specific needs, based on areas of expertise or client request.
6. Various interpreters have been contracted by the agency to break down language and cultural barriers within the community. Intake/Access workers will arrange for the use of interpreters as a need is identified. Intake/Access workers will have access to equipment for hearing-impaired callers, which is maintained by the receptionist staff.
7. Each unit conducting screenings also conducts a staffing/supervision after the screening to review, formally open, and assign clinical responsibility for each case. Staffings are attended by all unit staff, the Clinical Director or designee, and appropriate consultants (psychiatric). Because cases to be screened are briefly pre-screened, the majority of clients are assigned for treatment to the staff person who did the initial interview, thus assisting in continuity of care and comfort to the clients.
8. During the screening process, consumers and potential consumers are provided with information which enables them to make an informed choice about the use of the service, the range of other services available, and their rights to receive service in a manner which is non-coercive and which protects their right to self-determination.
9. It is also recognized that various channels do exist for direct referrals from the community to specific clinic programs. Specific contracts for services (such as psychological evaluations for DSS and court-ordered sex offender treatment) also take a different route through intake by management by designated staff. All of these activities are managed through clinical supervision.

Mental Health Services of Catawba County

Policies and Procedures

ACTIVITY: CLINICAL SERVICES SUBJECT: INTAKE/ACCESS SERVICES

EFFECTIVE DATE: 03/05/82 AMENDED DATE:11/10/00 NUMBER: 3.003b

10. In general practice, there is no necessity for a waiting list for adult and children outpatient services, as people are scheduled directly upon request of services. Special admission procedures within particular units do require waiting lists by virtue of their nature, i.e., ACT site, apartment living program, etc. Even when such waiting list are employed, all other available services to the client are utilized without delay. As always, anyone can be seen immediately on an emergency basis.
11. In the provision of services and assignment of clients, the goal is to assure continuity of care for the person served. In assigning clients to professional workers, the intake worker will strive to assign the client to the professional who will remain with the client throughout the service delivery period. In client assignment, staff will avoid arbitrary or indiscriminant reassignment which interferes with the helping relationship.
12. Tracking of service requests, referrals and disposition of services occurs through a computer generated tracking system.

Attachment I: Face Sheet

HISTORY NOTE: Authority G.S. 143B-147. APSM 30-1, 14v, Sections .0201 (4) (a) (b), .0201(6)(a)(b)(c). Policy effective 03/05/82. Approved QMT on 11/10/00 and 02/14/03. Amended effective 03/20/89, 01/12/95, 10/14/98, 09/22/00, 10/06/00, and 11/10/00.

G:\policy\amh\3003b

Attachment I

MENTAL HEALTH SERVICES
OF CATAWBA COUNTY

NC DIVISION OF MENTAL HEALTH
DEVELOPMENTAL DISABILITIES, &
SUBSTANCE ABUSE SERVICES

FACE SHEET DATA COLLECTION

Intake Priority: (Check Appropriate Response) __ Acute - 1 Hour ___ Urgent - 24 Hours ___ Routine - 72 Hours			
Date:	Service: ___ 80 - ES Phone ___ 47 - Intake Phone ___ 81 - ES face-to-face ___ 46 - Intake face-to face	Dur:	Time:
Client Name: (Last, First, MI, [Jr/Sr etc] Maiden)			Record Number:
Address #1:			
Address #2:			
City:	County:	State:	Zip:
Home:	Work Phone:	Contact Preference:	
Sex:	Race:	Marital Status:	
Date of Birth:	Unique ID:	Social Security:	
Employment Status:	Employer:		
Living Arrangement:	Number in Household:		
Education Level:	Child School Name:		
Guardian Info:	Address:		
Guardian Phone:	City/St/Zip:		
Referral Source:	Other Agency Involved:		
Presenting Problem:			
Suicidal? ___No ___Confirmed, as evidenced by:			
Homicidal? ___No ___Confirmed, as evidenced by:			
Psychotic? ___No ___Confirmed, as evidenced by:			
Developmental Disability? ___No ___Yes, as evidenced by:			
Substance Abuse History? ___ None ___ Alcohol ___ Other Drugs ___ Last Date of Use:			
Prior Treatment/Hospitalization:			
Med On Intake:			
Medical Problem:			
Diagnostic Impression:			
Disposition:			
Face Sheet Prepared By:		Therapist Number:	

Local Business Plan: Strategic Plan Matrix

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Contact	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	04/01/03

Item: V. Access To Care 1d

Goal: The local business plan describes the operation of a local access system in compliance with the uniform portal of entry and exit in the State Plan
-The document defines the roles of consumers and families in developing and monitoring the uniform portal system.

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Have current written policy regarding CFAC roles and responsibilities State's Consumer Satisfaction Survey completed annually, which addresses some aspects of Access satisfaction. Feedback is incorporated in planning. Individual Unit consumer satisfaction surveys completed annually at the time of the case manager's performance evaluation. This allows	Provide greater opportunities for consumers/families at all stages of planning through active solicitation of feedback about uniform portal system Develop systems to incorporate CFAC as part of monitoring team for Access Look at the feasibility of Client Rights Committee and CFAC sharing roles in oversight of LME functions, including Access	There is a significant amount of complex information for consumers to assimilate and implement with system change; this is an expanded role for consumers. Amount of time it takes to get usable results back from the State regarding the annual consumer satisfaction survey

case specific access issues to be addressed as indicated. Area Director and Clinical Director met with CFAC to gain direct feedback for ideas and suggestions to improve access	Involvement in the Western Region coalition of CFACs looking at issues of access along with development of a satisfaction instrument/tool Complete survey of a sample of callers to the Access system for data analysis of satisfaction elements (e.g., timeliness of appointments, consumer friendly, referral sources, etc.) Make outcome information available to monitoring sources, including consumers and families Explore the possibility and develop process for consumer/families to conduct anonymous test calls for info, referral and appointments – this will be one part of monitoring system accessibility and ease Explore existing Transitional Employment (TE) specifications and determine how roles can be expanded to include involvement in Access planning committee for those consumers involved in the TE program Linkage with other LMEs to monitor Access elements thereby increasing county program coordination	Amount of time required to train consumers to be part of a monitoring process to maximize their involvement

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
Contact	John M. Hardy, Area Director, (828)695-5900 , fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	O4/01/03

Item: V. Access To Care 1e

Goal: The local business plan describes the operation of a local access system in compliance with the uniform portal of entry and exit in the State Plan.
-A policy is evident that directs the tracking of service requests, referrals and disposition of requests.

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Policy and computer-generated form have been developed that direct the tracking of service requests, referrals and disposition of requests, including compliance with the DD Single Portal system	Consistently monitor report output for any indicated system changes that need to be addressed	

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
Contact	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	04/01/03

Item: V. Access To Care 2

Goal: The local business plan provides sufficient evidence of the capacity to support a system of uniform portal of access in compliance with the State Plan.
-There is a description of the proposed process for monitoring access to routine, urgent and emergent services indicating a capacity for managing a system that decreases waiting time for service and takes into account no-show rates and denials. Two years of data analysis (or a time frame for submission of two complete years of data) regarding access to emergent, urgent and routine care and follow up by age/disability is provided. This includes data and analysis regarding denials of care, no show rates and wait times for emergent/urgent/routine care

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Computer-generated data collection process in place, developed to gather all tracking data required upon completion of each initial contact for screening. Data includes no shows, #s per service request, wait time for emergent, urgent, or routine appointment by provider based upon clinical data. This process has been in place for 3 years, under regular review.	Develop a centralized Triage report to compile data, adding age and disability to data points already in place for more comprehensive tracking. Two years of consolidated data will be submitted in a future quarterly update.	Difficulty in tracking all necessary data elements and coding within the current computer system by efficiently extracting data for useable results. As this is an evolving process there is no complete mechanism currently in place to ensure that provider capacity is sufficient so that we can compensate with interim services if needed to meet service needs.

Tracking timeframes for emergent, urgent and routine appointments for assessment are kept in CMHC. In searching for appointment times Access unit knows how far out the appointment will be and if it is urgent they contact management staff for an earlier appointment and if emergent then Access staff will see during routine work hours of 8:00am-5:00pm. Emergency Services picks up after 5:00pm, including face-to-face at local hospitals if indicated. Access unit manager currently monitors the category of service requests against available appointments. Complaint/grievance procedures for all stakeholders are in place. The Single Portal process identifies no show, denials, wait time, etc. for monitoring purposes.	Per contract have each provider have electronic connect capacity. Identify service capacity within provider network by incorporating providers' data to the triage report for analysis and further development of the QPN. On-going evaluation of provider network for capacity and to identify trends to determine if there are needed shifts in personnel, revenue routing, categories of service provision, etc. Provider will contact LME if the referred client is a no show so care coordination/outreach can begin Include external provider network representatives to serve on QI/QA committee to help establish performance standards and review contract renewals Ensure stakeholder grievance procedure is continued and updated Explore varying options of Single Portal process	Need to have an electronic connection with all providers; however, there are many potential providers who do not have this capability. Funding mechanism and technical assistance would need to be provided to ensure the most efficient tracking and communication. Initially there is a lack of finances and personnel infrastructure to meet access best practice requirements with multiple points of entry and providers. Lack of definitions of care coordination and case management and how these functions fit into the process of referral, etc.

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
Contact	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	04/01/03

Item: V. Access To Care 3a

Goal: The local business plan indicates the number and location of designated entry points into the system and types of practitioners/programs that are being designated to perform such services.
-The number and location of entry points into the system are identified, and the types of practitioners and programs are sufficient to allow for timely and consumer-friendly access.
-An outline of the geographic area that indicates the location of facility-based services is attached.
-A policy is evident that identifies a 30 minute/mile standard for accessibility and recognizes the need for multiple accessible providers to enable consumer/community choice.
-The document assures that crisis stabilization services are available in sufficient quantity according to conclusions of the local needs assessment.
-The local Consumer Family Advisory Committee (CFAC) has documented review of all exceptions to the 30-mile/minute rule provisions

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Independent entry points in the MH/DD/SA system currently consist of DSS WorkFirst, local hospitals, 56 local childcare centers, local jails and the Criminal Justice Partnership Program, all within county boundaries	Add to entry points Review types of practitioners/programs already in place with facility-based services, matching those sites with client cluster areas in the community.	Lack of sufficient funding Long wait time for those referred to practitioners who accept Medicaid

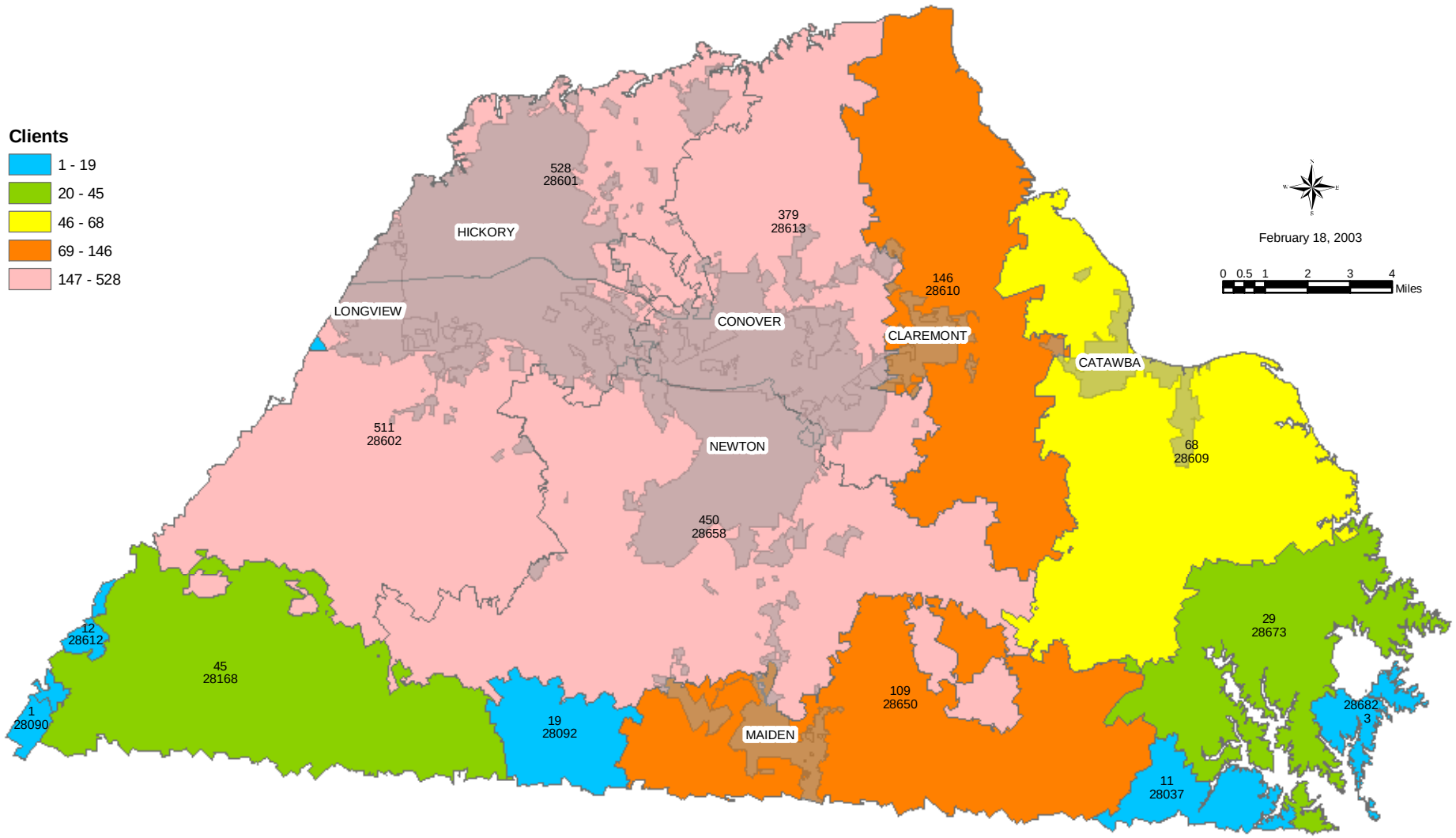
From our current centralized Access system, we have identified where active clients are clustered in the county. This is to compare current entry points to client locations in order to identify possibilities for future access points. (Attachment B) Developed a questionnaire sent to over 200 providers in 30-minute/30 mile radius to identify those who may or may not want to be considered in our provider network. Database was developed with this information. Policy was developed that identifies a 30-minute/mile standard for accessibility and recognizes the need for multiple accessible providers to enable consumer/community choice. (Attachment C) Crisis stabilization services currently provided are phone crisis intervention, face-to-face assessment, emergency case management, referral/linkage to local/state inpatient treatment facilities as well as referral to respite, PH programs, day treatment programs, detox, etc. Currently provide 24/7 response to crisis stabilization in catchment area. After-hours face-to-face crisis assessments occur at local hospital emergency rooms Expanded the ACT Team capacity within the last year to accommodate more clients and more services. More respite capability is available than in previous years due to increased funding for contract.	Work to incorporate these sites into the Access system. After training and privileging of staff at these sites, we will develop mechanism to monitor if programs/practitioners have the capacity to meet and maintain access demands. CFAC will be involved in this oversight. Develop mechanism for giving feedback to provider entry points if Access is doing well or needing to be improved. Further refine local needs assessment regarding availability of crisis stabilization services and work toward provision of crisis beds and partial hospitalization as identified in community needs assessment. Determine if crisis stabilization services are available in sufficient quantity to meet the needs of all persons in target population. Continue collaboration with community and neighboring programs regarding efficiency of current crisis services and expansion of crisis services Expand Emergency Services ability to respond to multiple facilities on-site CFAC will document review of all exceptions to the 30-minute/mile rule provisions per policy. CFAC role in addressing exceptions will be established both for crisis stabilization and service provision. This is addressed in separate CFAC report.	Limited number of practitioners who will accept non-target population without funding Inadequate funding for PH programs Difficulty in placements to regional/state inpatient facilities when necessary Inadequate funding sources for crisis respite State policy/standard for Access availability requirements set in place without consumer involvement.

Collaborative efforts with DSS CPS/APS, Public Health outpatient providers, and Adult Care Home providers to discuss and respond to crisis stabilization needs. Critical Incident Stress Management Team is in place to respond to community crisis 24/7 Conduct semi-annual meeting with local magistrates to review procedure/process/criteria for commitment and how to complete application Developed manual that includes information on Mental Health and State protocol/criteria for State Hospital admissions Administered a needs assessment for local community where crisis stabilization continuum of care was identified as a major need. (e.g., crisis beds, partial hospitalization, etc.)		

Reviewers Comments:

Attachment B – Catawba County Distribution of Active Consumers by Zip code (Map)
Attachment C – Draft Contract Provider Network Policy

Catawba County
Distribution of Active Consumers
by Zipcode



Notes: 2,489 Active Clients
2,369 In-County Active Clients
120 Out of County Active Clients

CCGIS
Catawba County
Geographic Information Systems

SOURCE: e:\projects\mental health\zip clients.mxd

DRAFT

Mental Health Services of Catawba County

POLICIES AND PROCEDURES

ACTIVITY: LOCAL MANAGING ENTITY (LME)

SUBJECT: CONTRACT PROVIDER NETWORK

Number:
Effective Date:
Amended Effective:
Approved:
QMT Approved: 02/14/03

POLICY:

Mental Health Services of Catawba County (MHSCC) shall make every reasonable effort to provide care to its citizens through a provider network. A network of providers will be maintained to provide an array of services within a 30 mile/minute radius to assure:

- accessibility to services
- consumer/community choice
- cultural diversity
- competence to treat co-occurring disorders
- skill at providing comprehensive one-stop service settings
- dedication to delivering consumer-directed supports
- compliance with the federal Synar amendment.
- screening and appropriate referral

PROCEDURE:

In order to assure competent, efficient and cost-effective services, as well as consumer choice of providers, the following procedure shall apply:

1. All eligible consumers will be informed of available resources and given a choice of providers.
2. Providers must possess the ability to provide "best practice" services for each target population.
3. Providers will comply with all MHSCC and DMHDDSAS requirements, including but not limited to the following:
    a. clinical expertise relevant to service provision and target population
    b. all licensure criteria
    c. any relevant accreditation standard
    d. liability insurance within established limits
4. Providers will comply with all federal and state fiscal requirements
5. Each provider will identify and actively pursue all first- and third-party collections
6. All providers will submit to MHSCC an audit report by an independent certified public accountant verifying compliance with all standards as well as a review and opinion of the financial status and internal fiscal procedures of the provider agency.
7. MHSCC will monitor activity referred to independent practitioners by percentage and number of actual requests and dispositions, as well as service units provided and costs of delivered services.

HISTORY NOTE: Approved by QMT 0n 02/14/03. Approved by the Mental Health Board on and effective on

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
Contact	John M. Hardy, Area Director, (828)695-5900, fax (828)695-5949, johnh@catawbacountync.gov
Submission Date	04/01/03

Item: V. Access To Care 4a

Goal: The local business plan describes a mechanism for provision of interim services that:
-Ensures due diligence in the search for services and supports outside of the boundaries of a single network; works across county lines to access services

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Through forums and educational formats, have included community supports in education on MH Reform and solicited/ gained their degree of availability for service provision. Established database of current providers and community resources both in-county and out-of-county	Strengthen community outreach to current resources providing services. Identify gaps in services through continued needs assessment. Assist non-traditional/faith-based/self-help types of resources to expand their services through collaborative efforts Develop resource booklet/clearinghouse on community resources for multiple needs (e.g., housing, transportation, emergency interventions for	Lack of sufficient funding to expand staff/services in network development

Established database of current contractual agencies, and have capacity for client-specific contracting where specialized or interim services are needed. Established system for tracking on additional providers as interest is expressed from the community, looking at contract possibilities Explored (and continue to explore) collaboration with other area programs around detox, geropsychiatric team, childrens' services, etc. Updated information available to staff for referral sources/options for clients, especially those in transitional status Identified communication frequency and transportation issues around services used outside of the county network, creating smooth system of care accessibility CFAC met with NAMI/ARC representatives to discuss advocacy and local support groups regarding access issues	food/clothing/funds, shelters, etc.) Explore possibility of contracting with other area programs for their provider network to supply services currently unavailable within our network. Maintain ongoing collaboration with other area programs as capacity and economy of scale needs are identified for interim services LME will provide brief services within available resources Collaborate with consumer groups and/or peer specialist in identification and expansion of network boundaries. Continue to collaborate with QPN committee	

Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Mental Health Services of Catawba County
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Submission Date	04/01/03

Item: V. Access To Care 5a

Goal: The local business plan adequately addresses physical and programmatic accessibility issues including the following:
-Limited English proficiency and other linguistic needs through the availability of language assistance services (such as American Sign Language interpreters, bilingual staff and/or interpreters) at no cost to individuals when requested, and written materials and signs are available in the languages of commonly encountered groups in the community.
-Cultural and demographic needs of the community.
-Visual impairments through written materials and signs translated into Braille, large print materials and non-technical language materials in buildings and accommodations for service.
-Alternative needs for communication through the availability of an augmentative communication specialist, if needed.
-Mobility challenges through accessible buildings (entrances ramped, restrooms wheelchair accessible, automatic door openers and elevators in multi-story buildings), parking lots with sufficient designated parking for vehicles with handicap permits.

Effective Date: 10/03

Steps Taken	Steps Planned	Barriers
Identified cultural diversity components of the community: 85% white, 8.4% African American, 5.6% Hispanic/Latino, 2.9% Asian Maintain contracts with interpreters (multiple languages and deaf/hard of hearing).	Identify in the provider report card the ability of each provider to meet the physical and programmatic accessibility requirements. Encourage importance of hiring and employing culturally diverse staff.	Lack of sufficient funding Non-traditional/faith-based services expected to meet accessibility issues

Bilingual staff available for on-site interpreter services. This service is supported by county stipend for those employees. Interpretive services are available by phone or in person; this includes the TTY phone system for deaf or hearing-impaired clients. Identified the need for more written materials and signs to be available in the languages of the most commonly encountered groups in the community All contract providers must comply with ADA . Cultural diversity training is available to staff on an on-going basis Utilize the augmentative communication specialist through the regional MR Center as needed Sidewalk entrance ramps, wheelchair accessible restrooms and doorways, automatic door openers, elevators with voice announcements, and parking lots with sufficient designated parking for vehicles with handicap permits are available to ensure accessibility to buildings.	Encourage facilities to be culturally and environmentally inviting (e.g. Spanish magazines in waiting room). Address accessibility of persons with visual impairments through written materials and signs translated into Braille, large print materials and non-technical language materials in buildings and accommodations for service Increase consumer involvement in reviewing the adequacy of services with oversight utilizing peer specialist (as identified by Division as best practice per PACT job description) Explore alternative needs for communication through the availability of an augmentative communication specialist, if needed Work to update and expand resources to meet accessibility needs, utilize the expertise and experience of interpreters in the development of a system that most accommodates special needs. Determine minimum standards to be requested of providers regarding accessibility issues and make explicit in contracting process.	Cultural differences in providing services; potential difficulty balancing culturally inviting services with efficiency in service provision (e.g. groups vs. individual, mixed gender treatment formats, etc.). The significant increase in some populations in a very short period of time with no time to adjust services to meet the need Lack of leadership at the State level around cultural diversity issues Limited availability of interpreters after-hours, along with the increased cost of interpreters if they do after-hours work Ability to enforce providers to comply with accessibility requirements without contractual language; this inability may limit expansion of the quality provider network.

Reviewers Comments: